Gleneagles Hospital
HONG KONG
港怡醫院

Consent for Radioactive Iodine Therapy (Thyrotoxicosis) Procedure and Treatment

For Clinic Use	For RTO Use
Please fill in or affix patient label	*Please fill in or affix patient label*
Name : M / F	Name : M / F
HKID No. : DOB :	HKID No. : DOB :
Contact No. :	Contact No. :

RADIOTHERAPY AND ONCOLOGY CENTRE

A. Person(s) Signing This Form (The Signatory)

The Patient is named in the right hand top corner of this Form.

The signatory signing this Form is/are: (Please tick "✓" as appropriate.)

- ❑ the patient.
- ❑ the parent or guardian of the patient who is a minor (age under 18).
- ❑ the patient's legal guardian appointed under Mental Health Ordinance (MHO) with power to consent to the proposed procedure / treatment.

Details of the ❑ parent / ❑ guardian / ❑ legal guardian appointed under MHO

Full Name(s)of Parent or Guardian ❑ HKID Card / ❑ Identity Document No of Parent or Guardian

B. Explanation of The Nature and Effect / Benefits Of The Procedure / Treatment

The doctor, who signs this Form, has explained the nature and effect / benefits of the procedure / treatment to the Patient and/or Patient's parent or guardian/ the Patient's legal guardian appointed under MHO as set out below:

1. The Patient's diagnosis / indications for the procedure / treatment: **Thyrotoxicosis (Hyperthyroidism)**
2. Name and nature of the procedure / treatment for the Patient: **Radioactive Iodine in Thyrotoxicosis**
3. The intended effect / benefits of the procedure / treatment for the Patient: **Radical Treatment**

C. The Risks and Complications / Side Effect Associated With The Procedure / Treatment

Early / Short Term Side Effects

These may occur during treatment, but usually disappear within a few days to several weeks later.

Uncommon

1. Decreased appetite.
2. Nausea and sometimes vomiting. This can be reduced by not taking too much food on the day of treatment.
3. Dry mouth; changes in or temporary loss of taste sensation; discomfort, soreness or swelling of the mouth or throat. Drinking plenty of water helps to reduce these symptoms.
4. Patients with thyroid eye disease (Grave's ophthalmopathy): Temporary worsening of eye swelling. This may be prevented by taking steroid. Your doctor will decide if this is necessary.
5. Patients with large thyroid swelling: Neck swelling or pain. This can be prevented by taking steroid. Your doctor will decide if this is necessary.

Rare

1. Temporary increase in thyroid activity, which may lead to worsening of the symptoms of thyrotoxicosis. This should not happen if you take anti-thyroid drugs as instructed by your doctor.
2. Allergic reaction resulting in skin rash, shortness of breath and drop in blood pressure. This is potentially life-threatening and may require resuscitation

Late / Long Term Side Effects

Some patients develop hypothyroidism (under-activity of the thyroid gland resulting in insufficient thyroid hormone secretion) some time after radioactive iodine treatment. Symptoms include weight gain, cold intolerance, easy fatigue, puffiness of the face and eyelids, constipation, slow pulse rate and hoarseness. About half of the patients develop hypothyroidism in the long run, and will require lifelong hormone replacement with thyroxine tablets. There is virtually no side effect from this.

Note:

- Radioactive substance can cause teratogenicity. Male and female patients should take contraceptive measures for a period of time as instructed by your doctor.

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- Female patients should avoid breastfeeding for a period of time before and after the radioactive iodine treatment as instructed by your doctor.
- Please tell your doctor if you need to be in close contact (within 1 meter) with babies or young children.
- Please tell your doctor if you had allergic reaction to iodine before.
- Please tell your doctor if you have received radioactive iodine in another hospital.
- Some statistical analyses suggested that there might be a slight increase in the risk of some kinds of malignancies. However, currently there is no conclusive scientific evidence that radioactive iodine for thyrotoxicosis definitely increases the risk of cancer.
- The dose of radioactive iodine used for treatment of thyrotoxicosis does not affect future fertility.
- It may be possible that the intended treatment outcome cannot be achieved, the disease may not be alleviated and it may recur or progress in the future.
- Despite all precautions, unpredictable and unpreventable adverse outcomes may occur after treatment. Please kindly read and fully understand the content above before deciding to proceed with the treatment.
- In the event of death, cremation may be denied by health authorities or may be deferred for a period of time depending on residual radioactivity.

❑ Refer to information sheet : _____

❑ Second course radiotherapy / Re-irradiation consent (same site as per item B.2 above)

D. The Risks / Complications For The Option Of No Treatment / Other Treatment: (If applicable):

For Surgery treatment, the risk include general anesthesia, wound bleeding, pain, infection, hypothyroidism etc.
For Medical treatment, the risk include hypothyroidism, allergy, joint pain, gastrointestinal upset, low white blood cell count, headache, liver enzyme impairment, hair loss etc.

E. Any Consequential Procedure(s) Which May Become Necessary During / Following The Procedure / Treatment (If applicable) : _____

F. Any Additional Treatment That Requires Prior Consent From The Patient Before Proceeding The Procedure (If applicable) : _____

G. Information Sheet (Please tick "✓" if applicable)

❑ I / We confirm that I / we have been provided with an information sheet on the procedure / treatment (copy attached), that I / we have reviewed and fully understand the contents.

H. Consent to The Procedure / Treatment

I / We, the undersigned Patient and /or Patient's parent or guardian/Patient's legal guardian appointed under the MHO:

1. consent to undergo / consent to the Patient undergoing the procedure / treatment set out above. The doctor (who signs this Form) has fully explained the nature, effects, benefits, general / specific risks and complications / side effect of procedure / treatment, to me / us which I / we fully understand.
2. understand other treatment options and their associated outcomes and risks. The doctor (who signs this Form) has answered any questions and enquiries raised by me / us which I / we fully understand.
3. consent to undergo / consent to the Patient undergoing such alternative or further procedures / treatment that the doctor(s) / health professional(s) may consider necessary or desirable.
4. understand that although the doctor(s) / health professional(s) will perform the procedure / treatment in the Patient's best interest, there is no guarantee of cure or improvement. Fully aware that the radiotherapy treatment is only delivered to targeted area, chances of disease progression, metastasis and/or recurrence may occur during or after the treatment.
5. understand the possible outcomes of **NOT** having the procedure / treatment. Aware that the procedure / treatment may be terminated as a result of disease progress or physical conditions of the undersigned Patient.
6. consent to undergo / consent to the Patient undergoing such tests and examinations that the doctor(s) / health professional(s) may consider necessary or desirable.

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7. understand that no assurance can be given by the hospital that the procedure / treatment, will be performed by particular doctor(s) / health professional(s). The doctors(s) / radiation therapist(s) who will perform the procedure / treatment will, however, be suitably qualified.
8. understand the described / said complications and risks of the procedure / treatment are not exhaustive. Rare complications may not be listed.
9. fully informed of the charges on such procedure / treatment and that extra fees shall be incurred if additional procedure / treatment considered necessary or desirable.
10. **For female patient only**: **I/We hereby confirm that I/the Patient undergoing the procedure/treatment am/is not pregnant and shall be responsible for all consequence should I/the Patient be found pregnant at the time of procedure/treatment.**
11. agree that this consent shall remain valid for 180 days from the date it was signed or the duration of one hospital admission even though the above procedure / treatment may be re-scheduled from time to time.
12. understand that, if I /we have any further questions, I / we can ask the doctor / health professional(s); and I /we have the right to withdraw my /our consent at any time after I / we have signed this form.

Signature(s) of Signatory(s)	Signature of Doctor	Signature of Witness (if applicable)
Full Name(s) of Signatory(s)	Full Name of Doctor	Full Name of Witness (if applicable)
Date	Date	Date (if applicable)

<u>This Part To Be Completed By Interpreter</u> *(Please fill in the below information if applicable)*

I _____ , _____certify that I have truly, distinctly and audibly
Full Name of Interpreter *HKID Card / Identity Document No.*

interpreted the consent of this document into _____ to the signatory.
Language / Dialect Used

Signature of Interpreter : _____ Date: _____

Note: The witness, if available, should be involved in the whole process, from explanation to signing of this Form.